# Family physicians and psychiatrists

## *Qualitative study of physicians' views on collaboration*

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ABSTRACT

**OBJECTIVE** To understand how to improve collaboration between psychiatrists and family physicians in primary care settings.

**DESIGN** Qualitative study using 10 in-depth interviews and a focus group session.

**SETTING** Catchment area in eastern Montreal, Que.

**PARTICIPANTS** Five FPs and five psychiatrists.

**METHOD** Ten interviews and a focus group were conducted to identify ways of improving collaboration between FPs and psychiatrists. All sessions were audiotaped and transcribed verbatim. Analysts used Atlas.ti to compare findings vertically and horizontally.

**MAIN FINDINGS** Three strategies were identified: communication, continuing medical education (CME) for FPs, and access to consulting psychiatrists. The first two can be implemented by FPs and psychiatrists together, but psychiatrists thought the last one was not feasible due to lack of both time and remuneration for such activity.

**CONCLUSION** Better communication and CME for FPs in psychiatry can help improve collaboration between FPs and psychiatrists. Increased access to consulting psychiatrists requires substantial alteration in established clinical roles and routines.

RÉSUMÉ

**OBJECTIF** Comprendre comment améliorer la collaboration entre les psychiatres et les médecins de famille en milieu de soins de première ligne.

**CONCEPTION** Une étude qualitative au moyen de 10 entrevues en profondeur et une séance de discussions avec un groupe témoin.

**CONTEXTE** Une circonscription hospitalière dans l'est de Montréal, au Québec.

**PARTICIPANTS** Cinq médecins de famille et cinq psychiatres.

**MÉTHODOLOGIE** Dix entrevues et une séance de discussions avec un groupe témoin ont été organisées pour identifier des moyens d'améliorer la collaboration entre les médecins de famille et les psychiatres. Toutes les séances ont été enregistrées sur bande sonore et transcrites mot à mot. Les analystes ont utilisé Atlas.ti pour comparer les constatations verticalement et horizontalement.

**PRINCIPAUX RÉSULTATS** Trois stratégies ont été identifiées: la communication, la formation médicale continue (FMC) pour les médecins de famille et l'accès aux psychiatres consultants. Les deux premières peuvent être mises en œuvre ensemble par les médecins de famille et les psychiatres, mais les psychiatres étaient d'avis que la dernière n'était pas faisable en raison d'un manque à la fois de temps et de rémunération pour une telle activité.

**CONCLUSION** Une meilleure communication et la FMC en psychiatrie pour les médecins de famille peuvent améliorer la collaboration entre les médecins de famille et les psychiatres. Un plus grand accès aux psychiatres consultants exige une modification substantielle des rôles et des habitudes cliniques établis.

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Family physicians are often the first professionals consulted when mentally ill people seek help.[1,2] Overall, FPs see the most patients with mental disorders,[3,4] and they play an important role in delivery of mental health care.[5] Because FPs cannot provide all the care mentally ill patients require,[6] they need to collaborate with other professionals.[6-9] The College of Family Physicians of Canada and the Canadian Psychiatric Association established a joint task force to study shared mental health care and to propose ways to improve the relationship between FPs and psychiatrists.[6]

Models of collaboration between FPs and psychiatrists have been described in various countries, such as England,[10,11] Australia,[12,13] and the United States.[14] Some models have already been shown to be effective in helping FPs detect and manage mental disorders.[15] In Canada, the McMaster Approach, a pioneering model of collaboration, has been described in detail,[16-20] as have other models in Ontario[21] and Quebec.[22]

In addition to these studies, a few studies investigated the dimensions of collaboration from practitioners' point of view. Williams and Wallace[23] surveyed both FPs and psychiatrists on how to improve written communication in patient referral. Psychiatrists and FPs were sent a questionnaire asking what fundamentally important information should be in a referral letter and in a psychiatrist's reply. The authors studied 100 referral letters in light of criteria thought to be important by FPs and by psychiatrists and found a fair amount of correlation between what psychiatrists expected and what they received in referral letters from FPs. They found very little correlation, however, between what FPs expected and what they received.

Bindman and colleagues[24] studied communication between FPs and psychiatric teams and FPs' views on their role in psychiatric care. Family physicians reported that they received little information from psychiatric teams; they perceived that their role in psychiatric care was limited to providing physical care and renewing prescriptions for psychotropic drugs.

Studying FPs' working arrangements with mental health providers and their attitudes toward developing closer collaboration with psychiatrists in primary care settings, Barber and Williams[25] found that FPs had primary care links with psychiatrists, psychologists, psychiatric nurses, and social workers. They also found that FPs had positive attitudes toward collaborating with psychiatrists in primary care settings.

Valenstein and colleagues[26] studied FPs' involvement in collaborative schemes with mental health professionals in community settings. The FPs indicated that they shared treatment of about 30% of their depressed patients with mental health care providers, who were contacted in only half the cases. The authors identified colocation of FPs' and mental health professionals' practices (in the same building) as an important factor for collaboration.

Most of these studies[24-26] investigated only FPs' perceptions of collaboration with psychiatrists. Only one study[23] included the views of both FPs and psychiatrists with respect to improving one dimension of collaboration. No study has investigated both FPs' and psychiatrists' views on how to improve several dimensions of collaboration. In light of this, and because qualitative methods have proven successful for examining questions in primary care,[27,28] we designed a qualitative study to elicit FPs' and psychiatrists' views on how to improve collaboration between them in primary care settings.

## METHOD

The study was conducted in Montreal, Que, between 1998 and 1999. The sample was composed entirely of FPs and psychiatrists who work in eastern Montreal, the catchment area of a psychiatric hospital, Hôpital Louis-H. Lafontaine, that serves a largely Francophone population of 356 077.[29] The hospital has reduced its number of beds drastically during the last 5 years in order to place greater emphasis on care in the community.[30] Hence, strategies for collaboration between psychiatrists and FPs are urgently needed.

Recruitment for the study began with identification of key informants who were thought to be involved in collaborative care, who could be accessed easily, and who could contribute to the study effectively. To meet basic criteria for inclusion in the study, physicians had to be practising FPs or psychiatrists and able to provide us with information on various aspects of collaboration between FPs and psychiatrists. Physicians who met the criteria were contacted by one of the investigators and invited to participate.

The number of participants was determined by when saturation was achieved[31]: when no further concepts were generated or new information obtained from physicians being interviewed, recruitment ended. As a result, 10 motivated and articulate physicians were selected: five FPs (three women, two

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men) and five psychiatrists (three men, two women). They all signed an informed consent form, which was submitted along with the study proposal for analysis and approval by the ethics and research committee of Hôpital Louis-H. Lafontaine.

Ten in-depth audiotaped interviews were conducted by one of the authors (R.J.M.L.) and a research assistant. About a week before each interview, the interviewer met the physician to be interviewed and gave him or her an overview of the study and a list of questions for the interview (on current working arrangements, perceived roles, expectations, and barriers and suggestions for improvement in collaborative care). Participating physicians could then begin to reflect on the questions and prepare for the interview. Family physicians were asked a direct question about improving collaborative care: "What should be done to make possible the kind of collaboration that you would like to have with psychiatrists?" Psychiatrists were asked, "What should be done to make possible the kind of collaboration that you would like to have with FPs?"

Interviews lasted an average of 90 minutes. Tapes were transcribed verbatim for analysis. The interviewer first read the transcripts of all interviews, then chose the two interviews (one with a FP and one with a psychiatrist) that gave the most diverse information on the study's themes and analyzed them according to a list of codes. The research assistant conducted a similar analysis independently. The coding list was compiled from the literature on collaboration, especially from *Shared Mental Health Care in Canada*[6] (prepared by a Joint Working Group of the Canadian Psychiatric Association and the College of Family Physicians of Canada). Each code on the list was assigned to one of the five sections, for example, the code "S-amelior/comuni" (*améliorer* [French] "to improve") was used to label all passages where participants suggested ways to improve communication.

The interviewer and the research assistant then compared their analyses and checked the consistency of the coding system by checking codes against their respective quotations. Some codes were redefined and others deleted, and new codes were added. To quantify the consistency of the coding system, we coded and recoded separately random segments (more than 100) of the transcripts of the two interviews. Then we calculated the code-recode reliability,[32] for segments coded by the same person (intracoder agreement) and for segments coded by both (intercoder agreement). Rates of agreement were 98% and 87%, respectively.

The interviewer coded the rest of the transcripts, and data were analyzed using Atlas.ti, version 4.1, which organized codes, quotations, memos, and conceptual networks in a single analytical unit (hermeneutic unit). Each interview had its own unit in the software, which allowed vertical (within the same interview) and horizontal (across interviews) analyses.

A summary of our findings was presented to each participant so he or she could provide feedback on the analysis of the content of interviews (confirmability). Subsequently, we arranged a focus group session to discuss the summary. Focus group discussion followed a guide based on the summary of results. The focus group lasted 2 hours, was conducted by a professional facilitator, and was audiotaped. The tapes were transcribed, and the same analysis procedure outlined above was applied to the transcript of the focus group session. This final encounter with participants enriched the findings of the interviews and highlighted psychiatrists' negative attitude toward on-site collaboration with FPs in primary care settings.

## FINDINGS

### Participants

All five psychiatrists practised at Hôpital Louis-H. Lafontaine (outpatient clinic or psychiatric emergency department) and were remunerated on a mixed system of sessional fees and fee-for-service. Two of the five FPs practised in CLSCs (local community service centres); two were in private practice; and one practised in a hospital emergency room. The FPs were paid either on a fee-for-service basis or on a mixed system. All 10 physicians in the study had practised for at least 10 years. Seven out of the 10 attended the focus group: four psychiatrists (two men, two women) and three FPs (two women, one man).

### Emergent themes

Analysis of participants' suggestions for improving collaboration revealed three main strategies: communication, continuing medical education (CME) in psychiatry for FPs, and access to consulting psychiatrists. This information was drawn directly from the transcripts.

***Communication.*** Psychiatrists and FPs agreed that written communication is easiest. The most common context for written communication is the referral process. According to participants, written communication

could be improved by having referring FPs request specific relevant elements of patients' clinical history (**Table 1**). Psychiatrists should focus their responses on two issues: diagnosis and the therapeutic plan, which should be organized as an algorithm (point-by-point management plan). An FP said, "Send us a response telling us, 'The steps we suggest are this; if this doesn't work, try this; if that doesn't work, then try this, etc'...."

**Table 1. Elements of FPs' consultation requests**

| |
|---|
| Diagnostic impression |
| Therapeutic approaches attempted so far (medication and dosage, type of psychotherapy, length of intervention, patient response) |
| Physical health problems |
| Previous psychiatric contacts |
| Aim of the consultation |

Telephone communication should be used for a quick exchange of information between FPs and psychiatrists who already work together and whose patients are known to both physicians. Calls should be scheduled for times when both FPs and psychiatrists are available to talk. During a referral, telephone communication between physicians should not be mediated by other professionals (eg, nurses or social workers); FPs and psychiatrists should talk to each other directly. Participants also stated that prior personal contact between FPs and psychiatrists facilitates telephone communication.

***Continuing medical education in psychiatry for FPs.*** Improving links in educational activities was thought important for collaboration. Planning for CME programs should include input from FPs on what they need to learn to improve their work with psychiatric patients. A psychiatrist said, "I think the first step is to ask ourselves what do [FPs] need as training. What will really attract FPs [to this training]?"

Participants suggested that psychiatrists and FPs from the same catchment area take leadership in organizing CME activities. They also suggested that CME activities take various forms (**Table 2**).

Family physicians considered psychiatrists' consultation reports as their principal and regular source of CME in the mental health field. Quick clinical exchanges with psychiatrists on the telephone also contributed to increasing FPs' skills in mental health care.

**Table 2. Suggested format for continuing medical education in psychiatry for family physicians**

| |
|---|
| Regular meetings to discuss cases and review relevant educational materials |
| Balint groups |
| Lunch or dinner lectures |
| Workshops |
| Half-day medication update seminars |
| Formal symposiums and conferences |

***Access to consulting psychiatrists.*** Psychiatrists in the study expressed their willingness to collaborate with FPs. The lack of both time and appropriate remuneration, however, prevented any of them from suggesting regular visits to primary care settings. They also thought it would be difficult for FPs to meet them at psychiatric services. One psychiatrist said:

> I do not have the energy to tour medical clinics. I think it would be a waste of time. … I am not even supposed to be paid if I am not on the premises of the hospital.

In contrast, all FPs described having had satisfactory experiences with visiting psychiatrists in primary care settings. All these experiences took place within the context of family medicine residency training, however; a visiting psychiatrist discussed cases with residents, and practising FPs were allowed to attend case discussions.

> At the family medicine clinic where I work we have a consulting psychiatrist who visits once a week. … This is ideal! I am fully satisfied.

Family physicians suggested a model to facilitate their access to psychiatric consultation: one consulting psychiatrist would be formally linked to one or several FPs. Once a week this psychiatrist would visit primary care offices or clinics to discuss complicated cases with FPs, help them with workers' disability issues, and when required, assess patients.

## DISCUSSION

Collaboration between FPs and psychiatrists seems to be more complex than reports imply.[6,8,9] Blount[33] explains that collaborative care between mental health providers and primary care physicians lies on a continuum that ranges from occasional courtesy

communication to on-site collaboration and teamwork. Health care professionals working in close collaboration need to share common values, perceptions, language, and thinking about their joint work to provide effective patient care.

Based on their experiences in the context of a family medicine residency program, FPs proposed a model to facilitate their access to psychiatric consultation. Similar models of on-site collaboration can be successful in specific contexts[16-20] and are one way of providing care, but they require substantial alteration of established clinical routines and professional roles. Hence, such models are difficult to apply in many practice contexts involving FPs and psychiatrists.

American surveys[34,35] indicated that psychiatrists dedicate most of their working time to direct patient care and some of it to administration, teaching, and research. It is understandable that it would be difficult for them to participate in extra activities (eg, collaboration with FPs). Moreover, they need particular skills (beyond those needed for traditional hospital psychiatry) to serve as consultants for FPs in primary care settings.[19,36,37]

By the same token, FPs work under very tight schedules[38,39] and deal with an array of medical problems that vary from childhood asthma and immunization to cancer screening to elderly people's congestive heart failure. In this context, detecting and treating psychiatric disorders might not be a priority.[40] In addition, fee-for-service remuneration motivates delivery of medical services quickly, in 8 to 12 minutes,[41] which is incompatible with the longer time (30 to 90 minutes[41]) required for psychiatric appointments.

Accordingly, it would be reasonable to take gradual steps in organizing closer working arrangements between FPs and psychiatrists. First, communication should be improved between FPs' offices and psychiatrists' clinics (which are the cornerstone of the current psychiatric network of services in our area and are the main link between the network and primary care offices[42]).

Then attention should be paid to non-traditional sources of CME for FPs in psychiatry, such as psychiatrists' consultation reports, and to the organization of CME activities based on FPs' perceived needs. Physicians' acceptance of a practice-based approach to the organization of CME activities has been described elsewhere.[16,19,43,44]

On-site collaboration schemes developed by individual FPs and psychiatrists[10] should receive appropriate administrative and financial support. Our findings

### Editor's key points

- This qualitative study explored family physicians' and psychiatrists' views on how to improve collaboration between their disciplines when psychiatric care is being provided in primary care settings. Three themes emerged: communication, continuing education in psychiatry for FPs, and access to psychiatrists.
- Family physicians wanted psychiatrists to make definitive diagnoses and provide explicit follow-up plans. Telephone communication was preferred because it was quicker and improved rapport.
- Continuing education for FPs in psychiatry in a variety of formats including case reviews, Balint groups, workshops, and conferences, was recommended.
- Psychiatrists did not believe their time would be well spent visiting individual FP's practices, despite FPs' considerable satisfaction when this occurred. An alternative model with one psychiatrist attached to several practices was suggested.

### Points de repère du rédacteur

- Cette étude qualitative explorait les points de vue des médecins de famille et des psychiatres sur les façons d'améliorer la collaboration entre leurs disciplines lorsque des soins psychiatriques sont dispensés dans des milieux de première ligne. Trois thèmes se sont dégagés: la communication, la formation continue en psychiatrie pour les médecins de famille et l'accès aux psychiatres.
- Les médecins de famille voulaient que les psychiatres posent le diagnostic définitif et fournissent des plans de suivi explicites. La communication par téléphone était privilégiée parce qu'elle était plus rapide et qu'elle améliorait les relations.
- On recommandait une formation continue en psychiatrie pour les médecins de famille sous diverses formes, notamment des études de cas, des groupes de Balint, des ateliers et des conférences.
- Les psychiatres n'estimaient pas que la visite dans des pratiques individuelles de médecine familiale serait un emploi avisé de leur temps, bien que les médecins de famille en éprouvaient beaucoup de satisfaction quand cela se produisait. On a suggéré un autre modèle selon lequel un psychiatre serait rattaché à plusieurs pratiques.

suggest that female FPs and young FPs,[25] young psychiatrists,[10,45] and FPs and psychiatrists practising in the same building[26] can engage more promptly in closer working arrangements.

## Future research

The opinions of both FPs and psychiatrists with respect to strategies for improved communication, CME for FPs in psychiatry, and access to consulting psychiatrists would be useful for planning for collaboration. Demographic and practice characteristics of physicians more likely to engage in collaborative care could also be identified. Studies exploring strategies for collaboration should use qualitative methods and should include FPs from both urban and rural areas and psychiatrists from both clinics and private practice.

## Limitations

Despite the diversity of the overall FP population,[46] the FPs participating in this study were quite homogeneous in their knowledge and positive attitude to detection and management of mental disorders in their patients. Therefore, strategies presented in this article might not be acceptable to FPs with different characteristics. Also, physicians' perceptions were collected through individual interviews and a focus group. No direct observation of participants in practice was used to validate the information collected.

## Conclusion

Collaboration between FPs and psychiatrists can be improved through more effective communication and organizing CME for FPs in psychiatry. These two strategies could lead to more positive attitudes among physicians and hence better collaboration than strategies that involve on-site collaboration in primary care settings.

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### Contributors

**Dr Lucena** *contributed to study conception and design; aquired, analyzed, and interpreted the data; drafted and revised the article for important intellectual content; and approved the final version for pubication.* **Dr Lesage** *contributed to study conception and design, assisted with interpreting the data, critically reviewed the content of the article, and approved the final version for publication.*

### Competing interests

*None declared*

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